PHILIPPINE SCIENCE HIGH SCHOOL SYSTEM

CAMPUS: _____

Paste your 1 x 1 picture here. **DO NOT STAPLE.**

HEALTH HISTORY AND PERSONAL DATA SHEET

Instructions:

Students should fill this up carefully **IN INK.** The answers to the questions will help the Medical Clinic in rendering effective treatment regarding your health problems. **ALL ANSWERS SHALL BE HELD CONFIDENTIAL.**

1. Name: _____
   First Name Middle Name Surname
2. Permanent Home Address: _____
   City Address: _____
3. Date of Birth: _____ Place of Birth: _____ Age: _____
4. Citizenship: _____ Religion: _____
5. Family Physician: _____ Contact No: _____
   Address: _____
6. **Family History**
   Father's Name: _____ Contact No:_____
   Address: _____
   Age: _____ ( ) Living ( ) Deceased Cause of death: _____
   Mother's Name: _____ Contact No: _ _____
   Address: _____
   Age: _____ ( ) Living ( ) Deceased Cause of death: _____
   Number of siblings: _____ Living _____Deceased Cause of Death: _____
   Order of Birth in the Family: ( ) First ( ) Second ( )Third ( ) Fourth ( ) Others: _____

Check (✔) which of the following diseases any of your relatives (up to first degree only) have had:

_____ Cerebral Hemorrhage	_____ Kidney Disease	_____ Hypertension	_____ Heart Disease
_____ Tuberculosis	_____ Asthma	_____ Migraine	_____ Diabetes
_____ Rheumatism	_____ Digestive Upset	_____ Allergy	_____ Bleeding Tendency
_____ Cancer	_____ Nervous Trouble	_____ Mental Illness	

_____ Others (Please Specify): _____

7. **Past History**

Check (✔) which of the following diseases/ illnesses you have had and write the age at which you had it. Put a cross (X) mark on those illnesses/ diseases which you have not had.

Chickenpox _____	Mumps _____	Amoebiasis _____
Measles _____	German Measles _____	Typhoid Fever _____
Hepatitis _____	Convulsion _____	Tetanus _____
Primary Complex _____	Dengue Fever _____	Tonsilitis _____
Pneumonia _____	Diphtheria _____	Whooping Cough _____
Influenza _____	Poliomyelitis _____	Diabetes _____
Appendicitis _____	Digestive Upset _____	Nervous Breakdown _____
Nosebleed_____	Bleeding Tendencies: _____	

Allergy _____ Pls. specify the triggering factors (allergen)_____

Asthma_____ Triggering factors of asthma: _____

Other illness (Please specify.) :_____

Have you ever been confined due to an illness? ( ) Yes Reason for confinement: _____

What year? _____

( ) No

8. **Immunization History**

Check **(✔)** if you have been immunized against the following diseases and indicate the year it was administered.

_____ DPT (Diphtheria, Pertussis and Tetanus Date: _____
_____ Poliomyelitis Date: _____
_____ Measles Date: _____
_____ Mumps: Date: _____
_____ German Measles Date: _____
_____ Hepatitis A Date: _____
_____ Hepatitis B Date: _____
_____ Chickenpox Date: _____
_____ Influenza Date: _____

9. **Menstrual History (for FEMALE STUDENTS)**

Age of Onset: _____ Average Duration of Menstruation (in days): _____
Amount ( ) scanty ( ) moderate ( ) profuse Occurrence: ( ) Regular ( ) Irregular
Presence of pain: ( ) before menstruation ( ) during menstruation ( ) after menstruation ( ) none
Intensity of Pain: ( ) mild ( ) moderate ( ) severe
Medications usually taken (list all): _____

10. Indicate your answers with a check **(✔)** mark.

a. Do you feel any of the following manifestations during stressful situations? ( ) YES ( ) NO

If yes, please check all that apply:

( ) stomach ache ( ) difficulty of breathing ( ) difficulty in swallowing
( ) dizziness ( ) palpitations ( ) immobility of hands and legs
( ) fainting ( ) allergy attacks ( ) nausea and vomiting
( ) loose bowel movement ( ) frequent urination

b. In what event do you usually experience the above mentioned symptoms?

( ) before exam ( ) contests ( ) quarrel with family/ friends/ significant others
( ) break-ups ( ) any classroom activity ( ) any activity facing a crowd of people
( ) hearing of bad news( ) Others (pls. specify): _____

c. Is the manifestation usually manageable? ( ) YES ( ) NO
d. If NO, do you seek medical attention? ( ) YES ( ) NO
e. Do you feel like someone is watching you even when there are no people around? ( )YES ( ) NO
f. Do you experience stage fright or fear of facing a crowd of people? ( ) YES ( ) NO
g. When you are in a sad/ depressed mood, how long does it usually last?

( ) 1 day ( ) 2-3 days ( ) 1 week ( ) 2-3 weeks ( ) 1 month ( ) more than a month

h. Do you usually share your problems / secrets to other people? ( ) YES ( ) NO

11. Are you allergic to any medications? ( ) YES If yes, to what medications: _____
( ) NO

_____
Printed Name and Signature
of Student